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Essential information for decision-makers

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In This Issue...

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Arizona pursues more direct role in outcome evaluation in Maricopa

Judge faults state for lack of progress

Stakeholders could argue for a long time about the historic shortcomings of the nation's largest public-sector behavioral health contract in Maricopa County, Ariz., but it is becoming clearer that close scrutiny is not among the features the program lacks. In recent months, it has arguably become more evident than ever that the success of this public behavioral health system stands as a major priority for state government, starting at the top with Gov. Jan Brewer.

Key Points...
- *State officials want to steer the move to a more outcome-driven system.*
- *Court bristles over progress in Maricopa, orders new status report.*
- *Magellan points to increasing community control in county program.*

"The new ingredient to the whole mix is that this is a high-priority item for the new governor; she has taken a leadership role," Will Humble, interim director of the Arizona Department of Health Services, told *MHW*.

While speculation abounds over whether the administration might align with a recommended system overhaul recently suggested in a report from the monitor of progress in a longtime lawsuit over deficiencies in the behavioral health system (see *MHW*, Jan. 26), state officials

See **Arizona** on page 2

State Budget Watch

Tenn.'s amended budget offers small ray of hope for MH community

Advocates still brace for community-based cuts

Tennessee's mental health community is savoring a small victory following last week's proposed budget amendment that would provide $10 million in recurring funds for safety-net services, including crisis stabilization and mobile crisis units, for individuals with serious mental illness.

Key Points...
- *Gov. Phil Bredesen amends budget to include $10 million for safety-net services.*
- *State faces $1.2 billion shortfall.*
- *Evidence-based, recovery-oriented services affected by state budget.*

Meanwhile, many in the mental health and substance abuse community are looking for the restoration of $6.7 million for several community-based services, slated for cuts or reductions in the governor's budget.

In his original budget proposal for fiscal year 2009-2010, unveiled in March, Gov. Phil Bredesen called for reductions in community-based mental health services and substance abuse services. The state is facing a $1.2 billion budget hole. The 2009-2010 fiscal year begins July 1.

The governor's budget proposal called for sharp reductions in

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for now say they are focused on stepping up efforts to evaluate Maricopa County program outcomes.

Humble, a former deputy director in the public health area, said last week that his department is working on coming up with some objective outcome-based criteria to evaluate the Maricopa program's performance, as part of an overall effort to move from a process-based evaluation to an outcome-based one.

"We just need to do a better job at our quality assessment, in collecting meaningful outcome data," Humble said. "This exists now, but much of the data resides with our contractors."

Yet while the administration intensifies its review of progress in the state's largest county, the state continues to take hits for the overall pace of its efforts. The Arizona Republic reported last month that at the latest court review of progress related to the longstanding class-action lawsuit Arnold v. Sarn, Arizona Superior Court Judge Karen O'Connor said state officials had largely ignored the findings of the January report from the court's Office of the Monitor. The judge has ordered the state to issue an updated progress report by early September.

The monitor's report suggested that there had been some backsliding in progress in Maricopa County since the state in 2007 replaced former managed care contractor ValueOptions with Magellan Health Services, Inc., which is now more than halfway through a three-year contract to manage the system. Looking at the status of a group of individuals with serious mental illness in Maricopa County, representing priority class members in the lawsuit, the monitor's office reported problems related to high caseloads and an insufficient focus on recovery.

'I don't believe this is a system in crisis. It is a system under transformation.'

Richard Clarke

While some observers have suggested that the program's long history demonstrates the need for a structural change toward a provider-driven system not under a large managed care contractor, others have said Magellan is making important progress on the main goals of the state and the court (see *MHW*, Feb. 2).

Community control

Richard Clarke, chief executive of Magellan's Arizona operation, last week reiterated his company's position from the time when the court monitor's report was released earlier this year: Data indicate that the Maricopa program is achieving improvements on several fronts, offering no sign that a major change in direction is needed.

"I don't believe this is a system in crisis. It is a system under transformation," Clarke told *MHW*.

He cited the growing role of community organizations in the Maricopa County program as a key element toward bringing about the recovery-driven service system that stakeholders are seeking. At present, 14 of 23 clinic sites in the system are under community ownership, he said, and by the time the next status conference is held in September all of the clinics will be under community control.

Clarke added that a community organization has been selected to assume ownership of the county program's urgent care center as well. Already, urgent care services have served as a potent example of Magellan's progress under its existing contract, Clarke said, as the program has seen a reduction in wait times for urgent care from the previous norm of a couple of hours to just minutes now. He added that the Joint

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Commission on Accreditation of Healthcare Organizations (JCAHO) recently awarded the urgent care center a "gold seal of approval."

Clarke pointed to other significant accomplishments since Magellan's arrival in Maricopa County:

- The program has stepped up participation from peers and family mentors in clients' treatment planning, with more than 80 percent of clients now receiving such assistance.
- The program continues to add organizations to its provider network, with recent additions serving to enhance both the recovery orientation and attention to issues affecting ethnic minorities.
- There has been a continued growth in use of innovative Assertive Community Treatment (ACT) teams to reach out to the most seriously ill clients and forestall crises such as homelessness. "We have a little over 1,600 people in ACT programs now," Clarke said. "We have the largest evidence-based practice model around ACT in the country."

Clarke added that an examination of national outcome measure data that is now furnished to the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that Arizona (for which Maricopa County represents two-thirds of the total profile) fares better than most states on measures such as client employment status, homelessness, and rehospitalization rates.

While he acknowledged the pressures at the state level to move faster in light of the longstanding court settlement issues, Clarke said Magellan remains focused to its ongoing effort to "move this thing under community control and then drive quality."

State officials appear poised to assume a more direct role in quality monitoring as well. Humble referred to his public health background in saying that the Department of Health Services' approach needs to resemble that of the state's response to the threat from the H1N1 virus: collect good surveillance data and use it to assess where you are and where you need to be.

Humble said it is too early to tell whether the governor's engagement on the behavioral health issue will lead to a call for a dramatic change in direction for the largest public-sector behavioral health program. Yet he added, "I think everyone recognizes that there's an opportunity right now because this is a priority for the new governor." •

Conn. center's smoking cessation program achieves 1-year success

A smoking cessation program, which included educational programs and incentives, at the New Haven-based Connecticut Mental Health Center is celebrating more than one year in helping both staff and patients eliminate smoking.

In a letter to the editor published in the May 2009 issue of Psychiatric Services, organizers of the center's cessation program noted that the center's entire campus officially became a smoke-free environment on April 7, 2008 and has remained so since. The Connecticut Mental Health Center, provides inpatient and outpatient services to individuals who have a severe and persistent mental illness, a substance use disorder, or both conditions.

The impetus for this effort occurred because of the alarm generated from the National Association of State Mental Health Program Directors (NASMHPD) report from two years ago, "Morbidity and Mortality in People with Serious Mental Illness," which noted that on average, people with severe mental illness die 25 years earlier than the general population (see *MHW*, July 23, 2006).

Key Points...

- *Cessation program prompted by NASMHPD report on mortality in people with SMI.*
- *Survey reveals staff would support smoke-free efforts, including their own.*
- *Encouragement, incentives, team effort key to program success.*

The NASMHPD report jolted the field. "That report was instrumental in helping us reinforce our commitment to moving forward faster concerning the need to help our patients not to smoke," Stephanie O'Malley, Ph.D., professor of psychiatry at the Yale University School of Medicine, and director of addiction services at the Connecticut Mental Health Center, told *MHW*. "We wanted to make the hospital [center] a smoke-free environment." The center is run jointly by the Connecticut Department of Mental Health and Addiction Services and Yale University.

Staff survey

The Connecticut Mental Health Center in January 2007 conducted a staff survey in order to assess attitudes about smoking cessation programs and to assist in policy development. It reported on its findings in last month's Psychiatric Services. About 175 staff members completed the survey.

The respondents had been asked to note their level of agreement with such statements as "Inpatients [or outpatients or staff] who smoke should be offered assistance to quit."Another comment discussed whether the entire facility

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and grounds should be smoke-free. According to the survey, most of the respondents had never smoked (61 percent), and 14 percent defined themselves as current smokers.

Most respondents agreed that assistance to quit smoking should be offered to inpatients (88 percent) and staff members (81 percent). The survey noted that a respondent's smoking status did not predict his/her attitudes about whether smoking cessation assistance should be offered to patients and staff.

In general, compared with former smokers and current smokers, a larger proportion of those who had never smoked agreed that the mental health center should be smoke-free. The survey noted that prior research has demonstrated that mental health and addictions staff who smoke are less likely to counsel their clients regarding smoking cessation.

The Connecticut survey did find that attitudes about whether the center should become smoke-free differed by smoking status. Staff members who were former or current smokers "were more ambivalent about the facility going smoke-free," said O'Malley. "That makes sense."

"The survey reported in this letter served to help the leadership of the Connecticut Mental Health Center to understand the origins of the resistance to a change to a smoke-free campus among staff," Selby Jacobs, M.D., director of the Connecticut Mental Health Center, told *MHW*.

"Also, it offered to a broad range of staff a voice in the process of change to a smoke-free campus, whether they agreed or not with the move."

The planning process

Through the smoking initiative, organizers were able to retain a broad perspective that involved nurses, representatives from peer support services, pharmacy, occupational therapy and teams from the inpatient-unit, said O'Malley. They were all engaged in the planning process, she said. "We trained as many clinicians as possible," she said.

An important component of a successful smoking cessation program is to provide services and encouragement to help staff quit smoking, O'Malley said. They should all be engaged in setting up policies and procedures, she said. O'Malley also stressed the value of NASMHPD's tool kit called "Tobacco-Free Living in Psychiatric Settings: A Best-Practices Tool Kit Promoting Wellness and Recovery."

They also developed incentive and educational programs. "We sponsored a 'Quit to Win' contest in which the staff members could sign up to quit smoking for a month and be eligible for a drawing to win a cash prize if they were successful," O'Malley said. Services were also provided to staff about medications for smoking cessation and community resources, she said.

"We also trained staff in smoking cessation counseling using clinical practice guidelines," O'Malley said. The medications used in the program included the nicotine patch, nicotine gum, bupropion (Zyban) and varenicline (Chantix), she said.

'It was an excellent example of how hospital staff can come together to work on improving the health of their patients.'

Stephanie O'Malley, Ph.D.

O'Malley noted that getting staff members to change their attitude toward smoking was a process. Once they realized the health benefits for patients, they found that the cessation program was worth pursing, she added.

O'Malley said she attributes the program's success to the staff's commitment. "It was an excellent example of how hospital staff can come together to work on improving the health of their patients," she said.

Jacobs added, "While a smoke-free campus is an inconvenience for smokers, it is part of a powerful, institutional message about the health effects of smoking and the Center's commitment to wellness. The data reported in the Psychiatric Services letter helped the center accomplish this essential change, he said. •

SAMHSA report: 1 in 13 adults had past-year depression

About 1 in 13 Americans ages 18 or older experienced a major depressive episode (MDE) in the past year, with particular subgroups — such as divorced or separated adults — having rates as high as 1 in 8, according to a report released last month by the Substance Abuse and Mental Health Services Administra-tion (SAMHSA).

An estimated 16.5 million people ages 18 years or older experienced at least one major depressive episode (MDE) in the past year and 64.5 percent of them received treatment, according to the report.

The report is drawn from SAMHSA's 2007 National Survey on Drug Use and Health (NSDUH), which collected data from 45, 437 persons ages 18 or older.

The rate of past-year MDE was lower among persons ages 50 or older (5.8 percent) than among those ages 18 to 25 or 26 to 49 (8.9

percent and 8.5 percent, respectively). Females were more likely than males to have experienced past-year MDE (9.5 vs. 5.3 percent).

Rates for past-year MDE were higher among divorced or separated adults (13.1 percent) than among those in any other marital status category (5.3 percent among married adults, 7.9 percent among widowed persons, and 9.2 percent among adults who had never married).

The prevalence of MDE was related to individuals' overall perception of health. The rate of past-year MDE was 14.2 percent among adults who reported that their overall health was fair or poor. In contrast, the rate of past-year MDE was 4.3 percent among those who reported that their overall health was excellent.

Treatment rates

Adults ages 50 or older who had MDE were more likely to have received treatment for depression than were those ages 18 to 25 or 26 to 49 (74.2 percent vs. 44.2 and 65.5 percent, respectively).

Females with past-year MDE were more likely than their male counterparts to have received treatment (68 percent vs. 57.8 percent). Adults who had not been married were less likely to have received treatment than those who were married or those who were divorced or separated (52.1 percent vs. 71.5 and 70.5 percent, respectively).

The report found that among adults with past-year MDE, 78.4 percent of those who reported that their overall health was fair or poor received treatment for depression, compared with 62.5 percent who said their health was good, 59 percent of those who said their health was very good, and 54.6 percent of those who said their health was excellent.

Type of treatment

Among those who received treatment for depression in the past year, 68.8 percent saw or talked to a medical doctor or other health professional about depression and used prescription medication for depression. In addition, 24 percent saw or talked to a medical doctor or other health professional about depression but did not use a prescription medication.

The study found that among those adults who saw or talked to a medical doctor or other health professional about depression, over three-fifths (61.9 percent) saw or talked to a general practitioner or family doctor. The remaining 7.1 percent took a prescription medication for depression, but did not see or talk with a medical doctor or other professional about depression. Also, 29.1 percent saw or talked to a psychiatrist or psychotherapist. A similar percentage (28.5 percent) saw or talked to a psychologist.

The report noted that because most adults with MDE consult or receive care from a family doctor, it is essential that general practitioners are kept up to date on the latest findings on screening and treatment for depression.

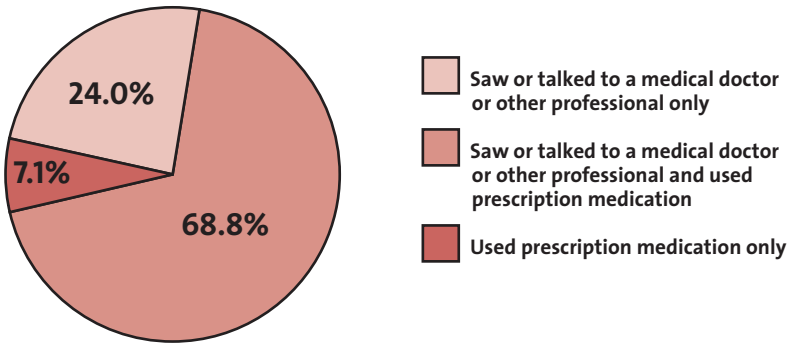
"This study helps us gain better insight into how many people suffer from major depressive episodes, where they seek treatment, and why they don't," said SAMHSA Acting Administrator Eric Broderick, D.D.S., M.P.H. "This information is critical to help inform health system reform."

According to the report, one-third of adults experiencing an MDE in the past year did not receive treatment during that period. The most frequently reported reasons for not receiving mental health services among these adults was not being able to afford the cost (43.2 percent), feeling they could handle the problem on their own (29.3 percent), not knowing where to go for services (18.1 percent), not having the time (16.7 percent), having health insurance that did not cover enough treatment (11.3 percent), and concerns about confidentiality (11.1 percent). •

"Major Depressive Episode and Treatment among Adults," is available on the web at http://oasbeta.samhsa.gov/2k9/149/MDEamongAdults.cfm. Copies may be obtained free of charge by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) or on the web at http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=18127. For related publications and information, visit www.samhsa.gov.

MDE and treatment for depression among adults: 2007

Type of treatment received among adults who experienced MDE and received treatment for depression in the past year*



* Respondents with unknown past year MDE data and treatment data were excluded. Percentages do not add to 100 percent due to rounding.

Source: 2007 SAMHSA National Survey on Drug Use and Health (NSDUH)

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behavioral health care. Recovery services were proposed to be cut by nearly $2.5 million. The proposal called for $978,000 in cuts for special populations, and approximately $154,000 in clinical services.

"The budget picture for any state department is very grim. We're particularly challenged in an already underfunded department," Virginia Trotter Betts, commissioner of the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD), told *MHW*.

"We were thrilled when the governor gave the final proposed [budget] amendment," she said. The department will receive an additional $10 million for the behavioral safety-net program, which provides services for individuals with a serious and persistent mental illness.

The Behavioral Health Safety Net of Tennessee and crisis programs for the uninsured were established in response to the decision to shift the TennCare program to a Medicaid-only program. The state restructured TennCare in 2005.

The state's safety-net population of 16,000 transferred from TennCare to the auspices of the TDMHDD. The $10 million amendment will help provide services through the Behavioral Health Safety Net to an additional 11,820 people with serious mental illness. Nearly 27,000 will now receive support, said Betts.

The services that will be covered for this population include psychiatric assessment, case management, medication management, and laboratory work.

Currently, 19 state community mental health centers offer behavioral health safety net services. The governor's budget amendment will also provide $2.4 million for the state's Cover Rx medication program for individuals with serious mental illness, said Betts.

"This is great news," said Betts. "We're very hopeful that the General Assembly will pass the amended budget."

Advocates weigh in

"We have quite a lot more hope now," Sita Diehl, executive director of the Tennessee chapter of the National Alliance on Mental Illness (NAMI-Tenn.), told *MHW*. "Ten million dollars, which is huge to us, will provide core services and $2.4 million will pay for medication management." Diehl said the governor's proposed budget amendment addresses some of advocates' concerns; however, they're also looking for $6.7 million to be restored for community-based services.

'We are pleased that the governor has reconsidered some of the previous decisions made about the mental health budget for fiscal year 2009-2010.'

Dick Blackburn

The governor's budget proposal had called for cuts to peer centers, criminal justice liaison and family respite programs, said Diehl. Under the proposal, three of the state's 49 peer support centers would close, she said. More than 200 positions, including those in peer-based programs across the state that hire people with mental illness, would [be] eliminated, Diehl said.

"Unless $6.7 million is restored to the budget, all of these programs, respite care, peer support and dual-diagnosis programs for people with co-occurring disorders will no longer be available," she said. The types of services affected are several innovative, evidence-based and recovery-oriented services, noted Diehl. "We realize this is a difficult budget year," she said. "We appreciate the administration amendment proposal of $12.4 million, which includes $2.4 million for medications."

"We are pleased that the governor has reconsidered some of the previous decisions made about the mental health budget for fiscal year 2009-2010," Dick Blackburn, executive director of the Tennessee Association of Mental Health Organizations (TAMHO), told *MHW*. "Up to that point, the mental health [arena] was the hardest hit of any state [entity]," he said.

Between the governor's original budget proposal in March and last week's decision to amend the budget, the mental health community was looking at a "dire situation," Blackburn said, although it's still not too great now, he conceded. "The ten million dollars made available to the department helps a lot."

Blackburn noted that the mental health department had to reallocate funding already in the budget, which accounts for the $6.7 million cut in community grants. "The department was losing a significant part of its budget," said Blackburn. "Those grants made up a significant portion of their budget. We supported that decision. It's more important to take the resources that have greater impact on the largest number of people with the [biggest] need."

Blackburn added, "Whatever resources are available ought to go to direct services and treatment programs to ensure providing those services to people that need it the most."

While the federal stimulus money did not do much to help mental health, it did free up state dollars, to the tune of about $16 million for TDMHDD, said Blackburn. A critical concern, he noted, is what is going to happen after fiscal year 2009-2010 when that one-time funding goes away, he noted. "How in the world are we going to survive a year losing $16 million for the next fiscal 2010-2011? We're hoping the economy improves," he said.

Lingering concerns

"Another bone of contention

for advocates is the phrase 'suitable accommodations,' which appears in both budget omnibus bills (Senate Bill 2357 and House Bill 2389), noted Diehl. The legislation defines "suitable accommodations" to mean that state psychiatric hospitals and Regional Mental Health Institutes (RMHIs) will no longer be required to admit patients regardless of the fact that they have been assessed as dangerous to themselves or others unless there is a suitable bed available at the facility.

"That budget language implies that these individuals would be driving around, handcuffed, in a sheriff's car in search of a bed," said Diehl. "That is unacceptable."

The Tennessee Coalition for Mental Health and Substance Abuse Services, in a letter delivered last week to the General Assembly, expressed its concerns about the provision, noting that the historical mission of RMHIs has been to provide a treatment resource for anyone in a psychiatric crisis, regardless of income, who needed a safe, medically-based, inpatient treatment environment.

Advocates remain concerned that if RMHIs do not accept these individuals, the local sheriff will be responsible for the patient who may require psychiatric hospitalization, with no place to house that person except jail.

"That's the uproar right now," Anita Bertrand, executive director of the Tennessee Mental Health Association, told *MHW*. "If the individual has not committed a crime, that person legally cannot be taken to jail. So will they write that person up for a misdemeanor or vagrancy, and take them in to get them off the street? There is some real concern."

Bertrand added, "There has to be some education about what other ways there are other than taking someone to the hospital. What are those alternatives?"

Potential layoffs

Meanwhile, last week the governor called on state lawmakers to lay off 717 state employees and abolish 656 vacant positions. The mental health department is expected to bear the brunt of those layoffs.

The Chattanooga Times Free Press reported that the state's Mental Retardation Services Division and the Department of Mental Health and Developmental Disabilities are the hardest-hit agencies, with a combined 552 existing positions slated for elimination over the course of fiscal year 2010.

Some of the staff cuts will come from the state's psychiatric hospitals, said Betts. As a result of the governor's proposed budget, the department has had to decrease inpatient capacity from 810 to 676 beds, she said. "That requires us to decrease staff at the hospital," she said. "We decided to go into the direction of growing crisis stabilization units and behavioral health safety net services."

The crisis stabilization units will provide services 24/7, said Betts. "We hope the crisis stabilization units will be seen by all in our community as a emergency room for people with mental health and substance abuse needs," she said.

"We are looking forward to January 2010 when the new federal parity regulation will be issued," she said. At least providers will no longer have to suffer under limited benefits that so many insurance companies are putting on mental health and substance abuse. We see a light at the end of the tunnel for those who remain insured." •

Briefly Noted

Bazelon Center applauds nomination of Judge Sonia Sotomayor

The Judge David L. Bazelon Center for Mental Health Law announced its support for President Obama's nomination of U.S. Appellate Court Judge Sonia Sotomayor to the U.S. Supreme Court. "Her empathy is evident," said Bazelon Center's Executive Director Robert Bernstein, "As is her understanding that judges' decisions interpreting these federal laws (such as the Americans with Disabilities Act) have real-life consequences…" In reviewing Judge Sotomayor's decisions, Bazelon Senior Staff Attorney Lewis Bossing said he was impressed by "how she has often engaged in searching inquiries into the nature of plaintiffs' impairments." For an analysis of selected court decisions by Judge Sotomayor, visit www.bazelon.org/issues/disabilityrights/sotomayor5-09.pdf.

Memorial to honor patients buried at psychiatric hospitals

A national memorial is planned for the grounds of St. Elizabeth's Hospital — The Garden at St. Elizabeth's: A National Memorial of Recovered Dignity — to honor hundreds of thousands of patients who have been buried at state psychiatric hospitals nationwide, many of them in unmarked graves. Mental Health America (MHA) reported May 27 that the memorial will join an existing 10-acre cemetery that inters around 4,500 psychiatric patients who died at St. Elizabeth's, the first federally-funded asylum. A dedication ceremony will take place at 10 a.m. on June 10, during MHA's Centennial Celebration and Conference.

NAMI honors 41 'Exemplary Psychiatrists'

The National Alliance on Mental Illness (NAMI) honored 41 "Exemplary Psychiatrists" at the annual conference of the American Psychiatric

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Association on May 25. "These doctors go above and beyond in their support of individuals and families, mental health advocacy and education," said NAMI Executive Director Michael Fitzpatrick. The honorees were nominated by individuals and families affected by mental illness. For a list of the honorees, visit www.nami.org.

Depression diagnosis varies significantly among ethnic groups

Seventy-six percent of whites with self-reported depression symptoms receive a diagnosis of depression from a physician, compared with 62.7 percent of Hispanics, 58.7 percent of blacks, and 47.4 percent of Asians, according to a recent Consumer Health Sciences study. CHS Chief Operating Officer Michael Fronstin said that while the cultural explanation for these variations is unclear, it is apparent from this study that "patients don't associate depression symptoms with the actual condition." He suggested, "We must provide the tools and training for medical providers and patients to be able to discuss depression, as well as its specific symptoms, in culturally relevant terms" to support increased diagnosis. Visit www.chsinternational.com to access the complete study.

State News

New Jersey considers requiring insurance coverage for autism

The New Jersey Assembly on May 21 approved a bill to expand health insurance for autism disorders. In a May 26 editorial in NorthJersey.com, Assembly Speaker Joseph Roberts wrote that New Jersey has the nation's highest rate of autism: 1 in 94 children compared to 1 in 150 nationally. Roberts co-sponsored the bill which would require health insurers to cover up to $36,000 in annual expenses for autism treatments judged to be "medically necessary," including speech and occupational therapy and behavioral intervention. The law would be limited to individuals aged 21 and younger. New Jersey would be the 11th state to enact such a law. The bill has advanced to the State Senate.

New online resource for California veterans and service members

California is the second state in the nation (Maryland was the first) to launch a Network of Care website — www.vets.networkofcare.org — for veterans and service members. The Contra Costa Times reported May 21 the site allows vets and service members to locate mental health programs, support groups and job information. The site was funded by mental health agencies in ten counties. Donna Wigand, Contra Costa County's mental health director, said that although the VA is "supposed to provide ongoing care, including psychiatric…that's not happening." Former State Assemblyman Bruce Bronzan, who founded the project, said many vets are "reluctant to go to a VA service."

Coming up...

Mental Health America (MHA) will hold its Centennial Conference, "Celebrating the Legacy, Forging the Future," on **June 10-13** in **Washington, D.C.** For more information, visit **www.mentalhealthamerica.net**.

The **U.S. Psychiatric Rehabilitation Association (USPRA)** will hold its annual conference, "Navigating the Depths of Psychiatric Rehabilitation," on **June 29-July 2** in **Norfolk, Va.** Visit **www.uspra.org** for more information.

The **National Alliance on Mental Illness (NAMI)** will hold its 2009 National Convention, "Creating a Healthy Future for us All," in **San Francisco** on **July 6-9**. Visit **www.nami.org** for more information.

The **Depression and Bipolar Support Alliance (DBSA)** will hold its 2009 National Conference on **September 10-13** in **Indianapolis, Ind.** For more information, visit **www.dbsalliance.org**.

Names in the News

Debra L. Wentz, Ph.D., executive director of the New Jersey Mental Health Institute, Inc. (NJMHI), was honored with Eli Lilly & Company's Welcome Back Award for Community Service. Wentz was recognized for her work with the NJMHI's Tsunami Mental Health Relief Project in Sri Lanka.

In case you haven't heard...

Exercise is a widely supported component of managing depression, so why not combine an elevated pulse rate with the joy of moving to music? "You can't be down when you're swing dancing," said Scott Burnett, the executive director of Mental Health America of Greater Tampa Bay. The Tampa Tribune reported May 22 that Burnett, an attorney and assistant professor of psychiatry at the University of South Florida, has been taking medication for depression for two decades. However, while his medication is invaluable, Scott says, "Socialization, spirituality and physical exercise are critical."